SWAAC
SOUTHWEST ALLERGY & ASTHMA CENTER

Patient Name: _____
Patient Address: _____
_____
City, State, Zip
Date of Birth: _____ Sex: _____
Daytime Phone: _____(Hm/Wk/Mb)
Allergist: _____

Confidential Voicemail Authorization

- Occasionally, it may become necessary to contact our patient(s) by telephone. In the event you are not available by phone, we will leave detailed voicemail messages regarding your/your child's treatment. By providing your telephone number(s), you hereby grant SWAAC permission to leave detailed voicemail messages regarding your/your child's treatment.

- o **My cell phone:** _____
- o **My Home phone:** _____
- o **Family Member** _____
- o **Other (name)**: _____

Phone Number: _____ **Phone Number:** _____

- o I do not wish to receive voicemail messages regarding my/my child's treatment.

Text/E-Mail Messaging Authorization

- To better serve you, we utilize text and/or email messaging for appointment reminders and important announcements. By providing your mobile number(s) and email address, you hereby grant SWAAC permission to contact you regarding appointment reminders and important announcements.

E-Mail:_____**Cell:**_____

- o I do not wish to receive text messages regarding appointments and important announcements.
- o I do not wish to receive emails regarding appointments and important announcements.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
*Legal Representative's Printed Name	Legal Representative's Signature	Date

_____
**If representative, specify relationship to patient*